Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DBA INJURY 1 DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

Respondent Name

ADVANTAGE WORKERS COMPENSATION

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-4575-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services were provided and the claims were paid incorrectly."

Amount in Dispute: $1,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have escalated the bill for additional review and it remains in process at this time."

Response Submitted by: Gallagher Bassett Services, Inc., 6401 International Parkway, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 11, 2011	Chronic Pain Management Program – CPT Code 97799-CPCA (7 hours per day)	$500.00/day	$437.50
March 15, 2011	Chronic Pain Management Program – CPT Code 97799-CPCA (8 hours per day)	$500.00/day	$312.50
TOTAL		$1,000.00	$750.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 13, 2011
   - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
   - W1-Workers compensation state fee schedule adjustment.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec.

   Explanation of benefits dated April 13, 2011
   - B12-Services not documented in patients' medical records.
   - W1-Workers compensation state fee schedule adjustment.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec.

Issues

1. Did the requestor's documentation support the billed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for the disputed services based upon reason codes "150-Payment adjusted because the payer deems the information submitted does not support this level of service"; and "B12-Services not documented in patients' medical records".

   A review of the submitted documentation supports the billing and reimbursement of the following services:

DATE	REPORT	TIME	TOTAL
March 11, 2011	Group Note Group Psychotherapy Note Massage Therapy Note Daily Rehab Worksheet Ice Manual Therapy	10-11 12-1 1-2:30 140 minutes 20 minutes 15 minutes	6:50
March 15, 2011	Group Note Hypnotherapy Group Note Group Psychotherapy Note Individual Progress Note Daily Rehab Worksheet Ice	10-11 11-12 12-1 1:05-1:35 160 minutes 15 minutes	6.5
TOTAL			13 hours

2. 28 Texas Administrative Code §134.204(h)(1)(A) states "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

   (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

   (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97799-CP-CA for thirteen hours. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is $125.00 per hour x thirteen hours = 1625.00. The carrier paid $875.00. Therefore, the difference between the MAR and amount paid is $750.00. This amount is recommended for reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $750.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $750.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	5/11/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.